STATE OF ALABAMA

DEPARTMENT OF INSURANCE

MONTGOMERY, ALABAMA

REPORT OF EXAMINATION

of

FIRSTCOMMUNITY HEALTH PLAN, INC.

HUNTSVILLE, ALABAMA

as of

DECEMBER 31, 2003

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EXAMINATION AFFIDAVIT

STATE OF ALABAMA
COUNTY OF MADISON

Tisha R. Freeman, being first duly sworn, upon her oath deposes and says:

That she is an examiner appointed by the Commissioner of Insurance for the State of Alabama;

That an examination was made of the financial condition of FirstCommunity Health Plan, Inc;

That the following 31 pages constitute the report thereon to the Commissioner of Insurance for the State of Alabama Department of Insurance;

And that the statements, exhibits, and data therein contained are true and correct to the best of her knowledge and belief.

Tisha R. Freeman

Tisha R. Freeman, Examiner-in-charge

Subscribed and sworn to before the undersigned authority this 25th day of October, 2004.

Charlene H. Williams
(Signature of Notary Public)

Charlene H. Williams, Notary Public
(Print Notary Public Name)

in and for the State of Alabama.

My commission expires: 6-5-07

BOB RILEY
GOVERNOR

STATE OF ALABAMA
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WALTER A. BELL
COMMISSIONER
DEPUTY COMMISSIONER
D. DAVID PARSONS
JAMES R. (JOHNNY) JOHNSON
CHIEF EXAMINER
RICHARD L. FORD
STATE FIRE MARSHAL
JOHN S. ROBISON
INTERIM GENERAL COUNSEL
TERRY RAYCRAFT
RECEIVER
DENISE B. AZAR
PRODUCER LICENSING MANAGER
JIMMY W. GUNN

October 20, 2004

Honorable William Bell
Commissioner of Insurance
State of Alabama
Department of Insurance
Post Office Box 303350
Montgomery, Alabama 36130-3350

Dear Commissioner Bell:

Pursuant to your instructions and in compliance with the statutory requirements of the State of Alabama and the resolutions adopted by the National Association of Insurance Commissioners, an examination has been made of the affairs and condition of:

FirstCommunity Health Plan, Inc.
Huntsville, Alabama

as of December 31, 2003, at its home office located at 699-A Gallatin Street, Suite A2, Huntsville, Alabama 35801.

Where the term, Company, appears herein without qualification, it is synonymous with FirstCommunity Health Plan, Inc.

SCOPE OF EXAMINATION

The Company was last examined for the four years ended December 31, 1999 by examiners representing the Alabama Department of Insurance. The current examination was conducted by examiners representing the Alabama Department of Insurance and covers the intervening period from the date of the last examination through December 31, 2003. Where deemed appropriate, transactions subsequent to December 31, 2003 were reviewed.

The examination was made in accordance with the statutory requirements of the Alabama Insurance Code and the Alabama Insurance Department's regulations and bulletins, in accordance with the applicable procedures and applicable guidelines promulgated by the National Association of Insurance Commissioners (NAIC), and in accordance with generally accepted examination standards.

The examination included an inspection of corporate records, tests of recorded income and disbursement items for selected periods, and a general review of records and files pertaining to operations, administrative practices and compliance with statutes and regulations. Assets were verified and valued and all known liabilities were established as of December 31, 2003, as shown in the financial statements contained herein. However, the discussion of assets and liabilities contained in this report has been confined to those items to which a material change was made, or which indicated a violation of the Alabama Insurance Code, or for which comments and/or recommendations were deemed appropriate. The Company's office copies of the filed Annual Statements for the period under review were compared with or reconciled to account balances with respect to ledger items.

The market conduct phase of the examination consisted of a review of the Company's plan of operation, territory, policy forms, advertising, compliance with agents' licensing requirements, member complaints, and treatment of members and claimants.

A signed certificate of representation was obtained during the course of the examination. In this certificate, management attests to the Company having valid title to all its reported assets, and that it did not have unreported liabilities as of December 31, 2003.

Within this report, discussion of the Company's accounts has been confined to those items for which a material change in the financial statements has been noted or for which comments and/or recommendations have been made.

ORGANIZATION AND HISTORY

The Company was formed on February 3, 1995 pursuant to the provisions of laws of the State of Alabama providing for the organization and regulation of nonprofit corporations for the establishment of health service plans. The Company was incorporated under the laws of the State of Alabama on July 23, 1996. The Bylaws provided for the Board of Directors to manage the property and business of the Company. The Bylaws further provided that the sole member of the Company would be the Health Care Authority of Huntsville, doing business as Huntsville Hospital. In its capacity as member, Huntsville Hospital would pay such dues and assessments as may be established by the Board.

A certificate of authority was issued on August 24, 1995, and the Company commenced business as "Tennessee Valley Community Health Plan" with reserves and unassigned funds totaling $475,639. The Company received no premiums or paid any claims prior to January 1, 1996. On September 22, 1997, the Company changed its name to FirstCommunity Health Plan.

On February 13, 1998, the Alabama Department of Insurance issued a certificate of authority for FirstCommunity Healthcare, Inc. (an HMO) that was a wholly-owned subsidiary of the Company. In 1997, the Company invested $1,000,000 in the stock of the HMO, which at December 31, 1997, was valued at $1,015,930 using the equity method. On March 29, 1999, the Company voluntarily surrendered the certificate of authority for the HMO to the Alabama Department of Insurance and verified that all of the HMO's groups were converted into the Company starting on that date.

In September 1999, the Health Care Authority of Huntsville's Board of Directors resolved to downsize the Company. All insured member groups of the Company, except for the Medicare Select group, would be terminated or non-renewed by September 30, 2000. See "Plan of Operation" page 13 for additional information.

There have been no other significant changes to the Company's structure or operations since September 30, 2000.

MANAGEMENT AND CONTROL

Board of Directors

The Company's Bylaws require that the Company have a minimum of fifteen members on the Board of Directors at all times. The Company was in compliance with the Bylaws with fifteen Directors as of January 1, 2003. However, two of the Directors resigned during 2003 and only one member was replaced during the year. Therefore, the Company only had fourteen Board members as of December 31, 2003. The members of the Board of Directors serving at December 31, 2003 were as follows:

Director/Residence	Principal Occupation
Charles August Grote, Jr., MD Huntsville, Alabama	Retired Physician
Benjamin Rogers King, MD Huntsville, Alabama	General Surgeon Private Practice
Tommie Lee Batts Huntsville, Alabama	Business Executive DP Associates, Inc.
Margaret Peterson Strickland Owens Cross Roads, Alabama	Executive Secretary Huntsville Convention & Visitors Bureau
Dorcas Sewell Harris Huntsville, Alabama	Retired Business Owner
Joseph Clyde Dowdle, PhD Huntsville, Alabama	Retired Engineer
Lee Roy Hoekenschnieder, Jr. Huntsville, Alabama	Banker AmSouth Bank of Alabama
Richard Aloysius Finch, MD Huntsville, Alabama	Retired Nephrologist

Nancy Palmer Rooks Huntsville, Alabama	Retired Principal & Educator
Nicholas Leonard Shields, Jr. Huntsville, Alabama	Scientist The Boeing Company
Joseph William Clark, Sr., MD Huntsville, Alabama	Orthopedic Surgeon The Orthopedic Center
Jack Edwin Bachelor, DMD Huntsville, Alabama	Retired Dentist
Shirley Richardson Hale Huntsville, Alabama	Retired President of Huntsville Botanical Gardens
Edward Earl Cobb Huntsville, Alabama	Retired Engineer

Financial Affairs Committee

The members of the Financial Affairs Committee as of December 31, 2003 were as follows:

Lee Roy Hoekenschnieder, Jr.
Jack Edwin Bachelor, DMD
Tommie Lee Batts
Benjamin Rogers King, MD
Robert Willis Chappell, Jr., MD

As of December 31, 2003, the Company was not in compliance with ALA. CODE § 10-2B-8.25(a) which states in part that the Board of Directors may create one or more committees and appoint members of the Board of Directors to serve on them. Robert Willis Chappell, Jr., M.D. was a member of the Company's Financial Affairs Committee, however, he was not on the Board of Directors.

Officers

The Officers serving at December 31, 2003 were as follows:

Officer	Position
David Allen Frederick	President
Jack Edwin Bachelor, DMD	Chairman
Nicholas Leonard Shields, Jr.	Vice Chairman
Shirley Richardson Hale	Secretary
Lee Roy Hoekenschnieder, Jr.	Treasurer*
Robert Willis Chappell, Jr., MD	Medical Director

*Lee Roy Hoekenschnieder, Jr. was appointed to fill the position vacated by Marcus David Byers, Jr. at the Board of Directors meeting held on December 2, 2003.

The management and service agreement between the Company and the Health Care Authority of Huntsville empowers the Health Care Authority of Huntsville to recommend the President and Medical Director, which the Company's Board can either approve or reject. David Allen Frederick was approved by the Board as President at the March 21, 2000 meeting of the Board of Directors. Robert Willis Chappell, Jr., MD was approved for his position as Medical Director at the August 22, 2000 meeting of the Board of Directors.

Conflict of Interest

Per the Company's Bylaws, Article III, Section 6. Disclosure of Interest: "Each Director,...shall submit in writing to the Chairperson...a list of all businesses, health care providers, or other organization of which he or she is an officer, director, trustee, member, owner..., shareholder with a five percent (5%) or greater interest...in which the Director would have conflicting interest, or which may compete with this Corporation. Each written statement will be resubmitted with any necessary changes each year."

The previous examination report recommended that the Company maintain the signed conflict of interest statements for each Board of Director for every year they serve on the Board. It was noted during this examination that the Company's Board members did not complete conflict of interest statements until after the 1999 examination was completed in July 2001. The current audit includes 2000 through 2004. The Company began completing conflict of

interest statements in 2001. The Company did not provide a conflict of interest statement for one of the Board members for the year 2001.

EMPLOYEE WELFARE

The Company did not have any employees. All individuals who performed administrative and operational functions for the Company were employees of Huntsville Hospital (Hospital). The Hospital offered the following benefits:

Earned Time Off
Voluntary Sick Plan
Group Health Insurance
Group Dental Insurance
Employee Badge Purchase Program
Flexible Spending Account
Health Care Authority 401(k) Plan
457 Deferred Compensation Plan
Group Life Insurance
Long Term Disability
Educational Assistance
Employee Assistance Program
Prescription Drug Benefits

During the review of Company operations, procedures were accomplished to determine if the Company had procedures in place to prevent persons convicted of a felony involving dishonesty or breach of trust from participating in the business of insurance. Within the Huntsville Hospital Employee Handbook, the Background Inquiries/ Reference Checks section stated that all information submitted by an applicant must be factual. This included the information on the employee application (to include background check form) and health screen form. With the employees' signed approval, a criminal background check will be conducted. Also within the Huntsville Hospital Employee Handbook, the Corporate Compliance section states that the Company is required to comply with all federal and state standards with an emphasis on preventing fraud and abuse and to report any behavior that may be considered illegal or unethical. All employees were required to attend Corporate Compliance training and must sign an annual Corporate Compliance affirmation statement. The examiner reviewed affirmation statements for all employees and one officer (President).

There was no specific documentation provided by the Company to evidence that the Company's officers, directors, and employees are not in conflict with Section 1033 of Title 18 of the US Code and ALA. ADMIN. CODE 482-1-121 (2003).

HOLDING COMPANY

This Company is organized as a nonprofit organization under ALA. CODE § 10-4-100 (1975); therefore, the Holding Company Act is not applicable to this Company.

MANAGEMENT AND SERVICE AGREEMENTS

Management Agreement with the Health Care Authority

The agreement provided included the Company's former name Tennessee Valley Community Health Plan. The Company has since changed its name from the Tennessee Valley Community Health Plan to FirstCommunity Health Plan, Inc. The management services agreement was entered into by and between The Health Care Authority of the City of Huntsville Alabama (hereinafter called "the Authority") and Tennessee Valley Community Health Plan (hereinafter called "the Plan").

Duties of the Authority

The Plan delegated full and complete responsibility of the Authority to manage, employ staff and conduct the day-to-day operations of the Plan and to perform functions in accordance with accepted management principles and in a manner consistent with all applicable statutory and regulatory requirements.

Relationship to Board of the Plan

The Authority reported to the Board of Directors of the Plan at regular meetings with respect to the performance of its duties under this agreement. The parties recognize that in an integrated delivery system there may be a need for other health plans depending upon the needs of the community and the Authority may develop such other health plans to meet such needs.

Personnel

The Authority had the responsibility to hire, engage, appoint and/or supervise and shall have the right to terminate the employment or engagement of all personnel necessary to carry out its obligations under this agreement. The Authority had the responsibility of the employment and termination of the President and Medical Director per the Plan's Bylaws. The Authority was also responsible for the salary and benefits of the President and/or Medical Director.

Space and Facility Maintenance

The Authority was to provide or arrange for all office space, including all cost associated with furnishing such office space, as reasonably necessary for the Authority to provide the services set forth in the agreement. Prior to breakeven, the space and facility cost is considered advanced costs. After breakeven, the space and facility cost will be considered a portion of the management fee.

Surplus note to secure indebtedness

The Authority hired Hospital Health Plan Corporation to develop the not-for-profit community health plan and agreed to expend the necessary money to implement the health plan. The Authority made an initial payment of Thirty thousand ($30,000) and a second cash payment of Two Hundred Fifty thousand ($250,000) to capitalize the Plan. The Authority further agreed to transfer to the Plan the sum of Two Hundred Fifty thousand dollars ($250,000), and the Plan issued to the Authority a surplus note to secure the cash payment. To provide for a mechanism for the Authority to be repaid for expenses incurred in developing and implementing the Plan, the Plan will execute a surplus note effective December 31 of each year a balance remains to be paid by the Plan to the Authority showing the entire balance owed by the Plan to the Authority with an interest rate as determined by the rates of interest published in the most current Wall Street Journal. It is intended for the surplus note to be cumulative of all prior indebtedness, whether current debt or debt secured by a previous surplus note.

Authority to negotiate contracts

The Plan delegated and appointed the Authority as its true and lawful attorney-in-fact for the purpose of negotiating and effectuating contractual issues for

and on behalf of the Plan with all providers of Health Care Services to Plan members including the Authority.

Information System

The Authority was responsible for implementing an information system for the support of the Plan's integrated managed care efforts. The Authority has all licensing rights to the information system and Authority agreed to apportion the costs of the system to the various managed care efforts of the Plan in a manner consistent with Medicare Cost Allocation procedures. The Authority was responsible for the ongoing operation, maintenance, and updating of the system. Prior to breakeven, the information system service, including hardware and software expenses, is advanced costs. After breakeven, the information system service will be considered a portion of the Management fees.

Fees and expenses

Monthly fee- The Plan was to pay the Authority an amount equal to 12.5% of the total premiums collected by the Plan from enrollees for the previous calendar month as the management fee. Any advanced cost and/or operating deficit were to be reimbursed through the 12.5% payment. Any operating deficit incurred after breakeven were borne by the Authority as a portion of the management fee. After the advanced costs and operating deficit have been repaid and the surplus notes retired, the Management fee is 8.0% of the total premiums collected each month by the Plan.

The Management Service Agreement stated that the Plan agreed to pay the Authority 12.5% of total premiums collected from enrollees in the prior month. However, the Plan was paying the Authority based on actual expenses incurred. This issue was also noted in the previous examination report.

During 2004, the Company revised its Management Service Agreement to state that the Plan will reimburse the Authority for actual expenses incurred. As of the completion of the examination, the Agreement had not been approved by the Alabama Department of Insurance. This issue was also noted in the previous examination report.

Excluded costs

The Plan had the financial responsibility for the following: any and all costs related to the delivery of health services and supplies to enrollees, including all

compensation and reimbursement paid to health care providers; the costs of reinsurance for the Plan; bad debt allowances and write-offs of the Plan; any amount by which coordination of benefit payments of the Plan exceed recoveries; federal, state or local taxes imposed on the Plan's income or premium revenue; fines or penalties imposed on the Plan that did not result from the actions or inactions of the Authority; any legal judgment entered against the Plan, except provided that the Board of Directors of the Plan was responsible for the judgment and the judgment was not the result of Authority's negligence, error or omission; sales commissions or brokerage fees to independent agents incurred in marketing the Plan with the Plan approval; extraordinary consultant expenses that were specifically requested by the Plan Board and not approved by the Authority; and any extraordinary expenses not identified in the published financial projections in the business plan of the Plan and which were authorized by the Board of Directors of the Plan after the financial projections were published.

Additional action requiring mutual consent

The Authority and the Plan expressly agreed that except upon the written concurrence of the other, neither will at any time do any of the following: amend the Articles of Incorporation or the Bylaws of the Plan; sell, lease or exchange all or substantially all of the property or assets of the Plan; merge or consolidate the Plan with any other corporation; dissolve the Plan or distribute the assets of the Plan; approve an annual budget for the Plan until all Advanced Costs and Operating Deficits are repaid; and transfer funds by grant, gift, or loan from the Plan.

Service Agreement dated August 26, 1998 between Nichols TXEN (Nichols) and FirstCommunity Health Plan

Nichols will process and pay claims according to the fee schedule and benefit plan data provided by the Company. A listing of specific responsibilities for Nichols and the Company was included in the contract. A listing of reports available for the Company to access as a part of the Managed HealthCare System was included in the contract.

Applications and programs supplied under the agreement include: Membership, Providers, References, Claims, Authorization and Referral Management, Member billing, Utilization Reporting, Accounts Payable and Accounts Receivable.

The Company's claims specialist conducts an internal claims audit not more than once every twelve (12) months. The claims selected for audits are one (1) percent of the total claims processed during the time period audited (usually a year). The claims audited were randomly selected by TXEN from the claims processing during the period of time being audited. A clean claim is defined as an invoice submitted for payment by a provider that has no defect or impropriety, including the lack of required substantiating documentation, or containing no particular circumstances requiring special treatment that prevents timely payment from being made on the claim. The Company's claims specialist reviewed 100% of the 1% random sample of total claims processed. Each audited claim was reconciled to the database.

Within the service agreement, there was a Performance Standard section which describes the claims standards of processing and payment accuracy by Nichols. If theses standards are not meet, there can be reductions of payment fees by the Company.

FIDELITY BOND AND OTHER INSURANCE

The Company was not a named insured on a fidelity bond for the year ending December 2003. However, the Company did not have any employees or real property. All people working at the Company were employees of Health Care Authority of the City of Huntsville (d/b/a Huntsville Hospital). Huntsville Hospital maintains a Fidelity/Employee Dishonesty bond in excess of the NAIC-mandated minimum for this Company. The Company was listed as a named insured on the Huntsville Hospital policy when it was renewed on June 30, 2004.

In addition, the Company was a named insured on the following policies:

Errors & Omissions Liability
Directors and Officers Liability

FINANCIAL CONDITION/GROWTH OF THE COMPANY

The following table sets forth the significant items indicating the growth and financial condition of the Company for the four-year period ended December 31, 2003.

YEAR	ADMITTED ASSETS	LIABILITIES	TOTAL CAPITAL AND SURPLUS	PREMIUMS EARNED	CLAIMS INCURRED
1999*	$7,997,623	12,167,646	$-4,170,023	$34,713,161	$35,802,060
2000	6,523,777	4,973,013	1,550,763	13,030,793	14,016,027
2001	4,705,305	1,485,015	3,220,290	4,554,791	1,722,092
2002	5,810,939	1,320,137	4,490,802	4,796,322	2,834,494
2003*	5,650,529	1,466,012	4,184,517	4,952,042	3,404,113

*Per Examination

MARKET CONDUCT AND RELATED ACTIVITIES

Territory

The Company was authorized to do business in the state of Alabama. At year-end 2003, the Company wrote business only in the counties of Colbert, Cullman, DeKalb, Jackson, Lauderdale, Limestone, Madison, Marshall, and Morgan.

Plan of Operation

Through September 1, 1999, the Company wrote commercial business and Medicare Supplement policies (Senior Select Plan A, Senior Select Plan B and Senior Select Plan C). As of September 1, 2000, the Company had no commercial business.

In July 1999, Company management decided to stop marketing its Medicare Supplement policies until such time as the claims' processing with its outside vendor was cleaned up and running smoothly. The Company started marketing its Senior Select products again in January 2001.

Compliance with Agents' Licensing Requirements

At December 31, 2003, the Company had 43 agents appointed to sell its products.

The examiners selected a sample of agents who received commissions and traced the sample to an Alabama Department of Insurance listing of agents who were appointed by the Company to write business.

There were no exceptions noted.

Policy Forms and Underwriting

The Company's Senior Select policies were approved by the Alabama Department of Insurance on July 29, 1997. The Company had a rate increase which was effective January 1, 2002. Subsequent to the period covered by this examination, on September 15, 2004, another rate increase was approved by the Alabama Department of Insurance to become effective January 1, 2005.

The only underwriting that the Company performed was verification that the applicants had Medicare coverage Parts A and B, no Medicaid with the exception of SLMB (Specified Low-Income Medicare Beneficiary), be 65 years of age, and live in North Alabama. Also the potential insured must not have had, or been advised to have, any organ transplant or applied for/using dialysis for kidney disease.

Advertising

The examiner reviewed all television scripts, radio and print ads. The ads disclosed the kinds of plans and benefits offered by the Company. The materials also included the name and address of the Company and identified the policy (Medicare Supplement) being marketed. None were misleading or guaranteed benefits different than what the certificates of coverage outlined. Also the examiner reviewed stamped approvals from the Alabama Department of Insurance for all advertised materials.

Within the marketing and sales procedures, a comparison was made of the Company's Outline of Coverage to the state law format in ALA. ADMIN. CODE 482-1-071-.17 (2002). It was noted that the Company did not include a "Policy Replacement" section in their Outline of Coverage. This section

advises the applicant not to cancel a pre-existing policy until after the new policy has been received and the applicant is sure they want to keep the policy.

Complaint Handling

The Company provided listings of complaints received from consumers for all four years under examination. There were 25 complaints received in 2003, 38 complaints received in 2002, 22 in 2001, and 44 in 2000. There were 32 out of 129 complaints for the four years under examination whose response was provided after 45 calendar days. Within the Company's Certificate of Coverage, the Problem Resolution Section stated that the Initial Grievance Committee is to issue a decision no later than 45 calendar days from the date an initial grievance is received.

The examiner reviewed fifty of the complaints received during the examination period. Other than the timeliness issue noted in the preceding paragraph, there were no other issues noted.

REINSURANCE

Assumed Reinsurance

The Company did not assume any business for the period under examination.

Ceded Reinsurance

The Company did not cede any business during the period under examination

ACCOUNTS AND RECORDS

The Company operated under a management agreement with the Health Care Authority. See "Management Agreement with the Health Care Authority" - Page 8 for details of this agreement. The Company does not have accounting personnel dedicated solely to it.

The software utilized to process the Company's accounting records has been Lawson since 2003. Claims were processed utilizing Nichols TXEN. See Page 11 for details of this agreement. During the course of the examination, the examiners were unable to electronically process some of the records provided by the Company as they were maintained in report format, instead of in

database-compatible formats (i.e. claims and the premium database). In addition, certain detail records were not provided to examiners in electronic format, including, but not limited to individual premium cash receipt transactions.

The Company was audited annually by the certified public accounting firm of Ernst & Young, LLP (E&Y). The examiners obtained and reviewed the audit reports for the years under examination. No management letters were issued.

The Company's reserves were certified by E&Y for the years under examination.

Consideration of Fraud

The Company had established procedures for reporting fraudulent insurance acts to the commissioner. There were no fraudulent acts detected during the course of the examination.

Within the Huntsville Hospital Employee Handbook, the Corporate Compliance section stated that the Company was required to comply with all federal and state standards with an emphasis on preventing fraud and abuse and to report any behavior that may be considered illegal or unethical. All employees were required to attend Corporate Compliance training and must sign an annual Corporate Compliance affirmation statement. The examiner reviewed copies of all signed affirmation statements for the Company employees for the years under review. The examiner found that one employee had not completed an affirmation statement for 2001.

Compliance with ALA. ADMIN. CODE 482-1-122

The Company's privacy procedures were reviewed for compliance with ALA. ADMIN. CODE 482-1-122. The Company provided Privacy Notices for 2003 and 2004. The Company provided these notices to applicants at the time of enrollment. The Company also sent out yearly updates for these notices. The Privacy Notice was also provided on the Company's website at www.firstcomm.org. The examiner determined that the Company's procedures were in compliance with the NAIC model regulation. The information disclosed within the Privacy Notices included areas such as the confidentiality and security of nonpublic personal information, information that is collected by the Company, parties to whom the Company may disclose information, the Company's uses and disclosure of protected health information, insured privacy

rights with respect to protected health information, the Company's duties with respect to the insured's protected health information, the insured's rights to file a complaint with the Company and the Secretary of the US Department of Health and Human Services, and the person or office to contact for further information about the Company's privacy practices.

FINANCIAL STATEMENTS

The financial statements included in this report were prepared on the basis of the Company's records and the valuations and determinations made during the examination for the year ended December 31, 2003. Amounts shown in the comparative for the years 2000, 2001 and 2002 were compiled from the Company's copies of the filed Annual Statements.

THE NOTES IMMEDIATELY FOLLOWING THE FINANCIAL STATEMENTS ARE AN INTEGRAL PART THEREOF.

FirstCommunity Health Plan, Inc.
Statement of Assets, Liabilities, Surplus and Other Funds
For the Year Ending December 31, 2003

ASSETS	Assets	Nonadmitted Assets	Net Admitted Assets
Cash and short-term investments (Note 1)	$ 5,593,416	$	$5,593,416
Uncollected premiums and agents' balances in the course of collection	1,505		1,505
Net deferred tax asset	6,472,288	6,416,680	55,608
Prepaid Administrative Insurance	24,465	24,465	0
TOTAL ASSETS	**$12,091,674**	**$6,441,145**	**$5,650,529**

LIABILITIES, SURPLUS AND OTHER FUNDS		
Claims unpaid **(Note 2)**		$1,065,537
Unpaid claims adjustment expenses **(Note 3)**		156,634
Premiums received in advance		46,889
General expenses due or accrued **(Note 4)**		156,524
Current federal and foreign income tax payable	**(Note 5)**	8,500
Amounts due to parent, subsidiaries and affiliates		31,928
Aggregate write-ins for other liabilities **(Note 6)**		0
TOTAL LIABILITIES		**$1,466,012**

CAPITAL, SURPLUS AND OTHER FUNDS	
Contributed capital	$25,975,245
Restricted Capital Note	1,300,000
Nonadmitted Assets	-24,465
Nonadmitted deferred tax asset	-6,416,680
Unassigned funds (surplus) **(Note 7)**	-16,649,583
TOTAL CAPITAL, SURPLUS AND OTHER FUNDS	**$ 4,184,517**
TOTAL LIABILITIES, CAPITAL AND SURPLUS	**$ 5,650,529**

THE NOTES IMMEDIATELY FOLLOWING THE FINANCIAL STATEMENTS ARE AN INTEGRAL PART THEREOF.

FirstCommunity Health Plan, Inc.
Statement of Revenues and Expenses
For the Years Ended December 31, 2000, 2001, 2002, and 2003

	2000	2001	2002	2003
Underwriting Income:				
Net Premium Income	$13,030,793	$4,554,791	$4,796,322	$4,952,042
Total Revenues	$13,030,793	$4,554,791	$4,796,322	$4,952,042
Hospital and Medical:				
Hospital/medical benefits	$14,016,027	$1,722,092	$2,834,494	$3,404,113
Less net reinsurance recoveries	0	52,087	99,462	0
Total medical and hospital	$14,016,027	$1,670,005	$2,735,032	$3,404,113
Claims adjustment expenses		451,898	444,731	635,246
General administrative expenses	2,893,762	881,527	739,240	965,313
Total underwriting deductions	$16,909,789	$3,003,430	$3,919,003	$5,004,672
Net underwriting gain or loss	$-3,878,996	$1,551,361	$ 877,319	$ -52,630
Net investment income earned	203,602	157,782	74,500	24,787
Net income or loss before federal income taxes	$-3,675,394	$1,709,143	$ 951,819	$ -27,844
Federal and foreign income taxes incurred	$ 0	$ 30,510	$ 0	$ 0
Net income or loss	$-3,675,394	$1,678,633	$ 951,819	$ -27,844

THE NOTES IMMEDIATELY FOLLOWING THE FINANCIAL STATEMENTS ARE AN INTEGRAL PART THEREOF.

FirstCommunity Health Plan, Inc.
Capital and Surplus Account
For the Years Ended December 31, 2000, 2001, 2002, and 2003

	2000	2001	2002	2003
Capital and surplus prior reporting year	$-3,049,138	$ 1,550,763	$ 3,220,290	$4,490,802
GAINS AND LOSSES TO CAPITAL AND SURPLUS				
Net income	$-3,675,394	$ 1,678,633	$ 951,819	$ -27,844
Change in net deferred income tax		-3,990,986	2,542,349	-61,046
Change in nonadmitted assets		-9,107	-2,223,656	-217,396
Cumulative effect of changes in accounting principles		3,990,986		
Restricted capital note	1,300,000			
Contributed capital	6,975,295	0	0	0
Net change in capital and surplus	$ 4,599,901	$ 1,669,526	$ 1,270,512	$ -306,286
Capital and surplus end of reporting year	$ 1,550,763	$ 3,220,289	$ 4,490,802	$4,184,517

THE NOTES IMMEDIATELY FOLLOWING THE FINANCIAL STATEMENTS ARE AN INTEGRAL PART THEREOF.

NOTES TO FINANCIAL STATEMENTS

Note 1 – Cash and short-term investments **$5,593,416**

The captioned amount is the same as reported by the Company in the 2003 Annual Statement.

ALA. CODE § 35-12-23 (b) states that funds are not considered "unclaimed funds" until they have been unclaimed and unpaid for more than five years after the moneys became due and payable. As of December 31, 2003, there were 593 checks on the outstanding check listing of the bank reconciliation that were issued from 1996 to 2003. There were 42 checks issued from 1996, 1997 and 1998 that should have been submitted to the Unclaimed Property Division of the State of Alabama Treasury Department in 2001, 2002 and 2003, respectively. On April 1, 2004, the Company mailed letters to customers on the outstanding check listing that had checks outstanding from 1996 - 1998. This letter stated that replacement checks would be issued to all customers who contacted the Company no later than the end of business on April 30, 2004. Replacement checks were issued to the nineteen people that responded. The funds for the remaining 23 checks, totaling $2,222, were sent on April 30, 2004 to the Unclaimed Property Division.

Note 2 - Claims unpaid **$1,065,537**

The captioned amount is the same as reported by the Company in the 2003 Annual Statement.

For the completion of the Underwriting and Investment Exhibit- Part 2A, the components to be included were due and unpaid claims, in course of settlement claims, incurred but not reported claims and unpaid claim adjustment expenses. The Annual Statement blank for health insurance companies includes two categories for the Underwriting and Investment Exhibit- Part 2A, Reported in Process of Adjustment (which would correspond to the sum of due and unpaid and in course of settlement) and Incurred but Unreported. The Company included all claim liabilities under the one category of Incurred but Unreported.

It was also noted that the Company did not follow Annual Statement instructions to show a breakdown by number of days of aging of claims for

Exhibit 5- Claims unpaid and incentive pool, withhold and bonus. The Company only showed a total.

The Health Insurance Reserves Model Regulation states, "The premiums for the rating block were developed such that each year's premium is intended to cover that year's costs without any prefunding." This is required language in the actuarial opinion when community rating is used and the Company uses community rating. This language was not included in the Company's actuarial opinions for the years under review.

Note 3 – Unpaid claims adjustment expenses **$156,634**

The captioned amount is $135,313 more than the $21,321 reported in the 2003 Annual Statement.

The claims adjustment expense shown in the 2003 Annual Statement as a percentage of the incurred claims shown in the 2003 Annual Statement was 14.7%. The previous year's percentage was 15.7%. Applying the 2003 percentage to the 2003 claim liability gives the claims adjustment expense of $156,634. The Company used 2%, which is a significant difference from the actual percentage of 14.7% ratio as shown in the 2003 Annual Statement.

Note 4 – General expenses due or accrued **$156,524**

The above captioned amount is $120,073 greater than the $36,451 reported in the 2003 Annual Statement.

It was noted that the Company did not include an accrual for $72,073 in expenses in the 2003 Annual Statement that related to 2003 filing fees, privilege taxes, the preparation of income taxes and the auditing of the financial statements.

It was also noted that the Company included $48,000 for accrued broker commissions in the Aggregate write-ins for other liabilities. According to the NAIC Annual Statement Instructions, this amount should be included in General expenses due or accrued.

Note 5- Current federal and foreign income tax payable **$8,500**

The captioned amount is $8,500 greater than the $0 reported in the 2003 Annual Statement.

It was noted that the Company incorrectly reported the 2003 income tax accrual as a write-in on line 2102 of the Liabilities, Capital and Surplus page of the 2003 Annual Statement. According to the NAIC Annual Statement Instructions, federal and foreign income taxes due or accrued should be reported on the Liabilities, Capital and Surplus page on line 10.1 - Current federal and foreign income tax payable and interest thereon.

Note 6 - Aggregate write-in for other liabilities (Accrued income taxes and Accrued broker commissions) **$0**

The captioned amount is $56,500 less than the amount reported in the 2003 Annual Statement.

The Company incorrectly reported the 2003 income tax accrual ($8,500) as a write-in on line 2102 of the Liabilities, Capital and Surplus page of the 2003 Annual Statement. According to the NAIC Annual Statement Instructions, federal and foreign income taxes due or accrued should be reported on the Liabilities, Capital and Surplus page on line 10.1 - Current federal and foreign income tax payable and interest thereon.

The Company included $48,000 for accrued broker commissions in the Aggregate write-ins for other liabilities, line 2101 of the Liabilities, Capital and Surplus page of the 2003 Annual Statement. According to the NAIC Annual Statement Instructions, this amount should be included in General expenses due or accrued.

Note 7 – Unassigned funds (surplus) $-16,649,583

The captioned amount is $207,386 less than the $-16,442,197 reported in the 2003 Annual Statement.

This difference resulted from the following examination changes.

Unassigned funds per Company's 2003 Annual Statement		$-16,442,197
Examination (decreases) to assets:		
None	$ 0	
Total decrease to assets		**$ 0**
Examination (increases) to liabilities:		
Unpaid claims adjustment expenses	$(135,313)	
General expenses due or accrued	(120,073)	
Current federal income tax payable	(8,500)	
Aggregate write-ins for other liabilities	56,500	
Total (increase) to liabilities		**$ (207,386)**
Total (decrease) to surplus		$ (207,386)
UNASSIGNED FUNDS PER EXAMINATION		**$-16,649,583**

COMMENTS AND RECOMMENDATIONS

Board of Directors – Page 4

It is recommended that the Company maintain a minimum of fifteen members on the Board of Directors at all times as required by the Company's Bylaws.

It is recommended that the Company only appoint members of the Board of Directors to serve on committees as required by ALA. CODE § 10-2B-8.25(a).

Conflict of Interest – Page 6

It is again recommended that the Company maintain conflict of interest statements, signed annually, for all officers and directors.

Employee Welfare- Page 7

It is recommended that the Company maintain documentation to provide evidence that its employees, officers and directors are not in conflict with Section 1033 of Title 18 of the US Code and ALA. ADMIN CODE 482-1-121 (2003), which prohibits certain persons from participating in the business of insurance.

Management and Service Agreements – Page 8

It is again recommended that the Company operate in accordance with its management services agreement.

It is again recommended that the Company have its management agreement with the Authority approved by the Alabama Department of Insurance.

Fidelity Bond and Other Insurance - Page 12

It is recommended that the Company maintain evidence of being a named insured on a fidelity bond which meets the NAIC-mandated minimum.

Advertising- Page 14

It is recommended that the Company revise their Outline of Coverage to include a "Policy Replacement" section as instructed in ALA. ADMIN. CODE 482-1-071-.17 (2002).

Complaints handling- Page 15

It is recommended that the Company issue a decision no later than 45 calendar days from the date an initial grievance is received as required by the Company's Certificate of Coverage.

Accounts and Records – Page 15

It is recommended that the Company maintain detail records, in electronic format compatible with Excel, Lotus, dbase iii, ASCII or EBCDIC files.

Consideration of fraud- Page 16

It is recommended that all Company employees sign affirmation statements in accordance with the Corporate Compliance Program of Huntsville Hospital.

Cash and short-term investments - Page 22

It is recommended that the Company comply with ALA. CODE § 35-12-23 by annually remitting funds that have been unclaimed and unpaid for more than five years after the moneys become due and payable.

Claims unpaid- Page 22

It is recommended that the Company record claim liabilities in accordance with Annual Statement instructions for the Underwriting and Investment Exhibit Part 2A and not report all claim liabilities in one category.

It is recommended that the Company follow Annual Statement instructions and complete Exhibit 5 in accordance with those instructions and provide the proper aging of unpaid claims.

It is recommended that the consulting actuary include the following language in the actuarial certification provided with the annual statement in future years,

"The premiums for the rating block were developed such that each year's premium is intended to cover that year's costs without any prefunding."

Unpaid claims adjustment expenses – Page 23

It is recommended that the Company establish an adequate unpaid claim adjustment expense by applying the correct percentage of unpaid claims adjustment expenses as determined by dividing the claim adjustment expenses incurred shown in the annual statement by hospital and medical claims incurred during the year as shown in the Annual Statement.

General expenses due or accrued- Page14

It is recommended that the Company include an accrual for expenses in order to match all expenses to their related periods of income/claims.

It is also recommended that the Company include accrued commissions in General expenses due or accrued as required by the NAIC Annual Statement Instructions.

Current federal and foreign income tax payable- Page 24

It is recommended that the Company report accrued income taxes on line 10.1 of the Liabilities, Capital and Surplus page of the Annual Statement as required by the NAIC Annual Statement Instructions.

COMPLIANCE WITH PREVIOUS RECOMMENDATIONS

A review was conducted to determine if the Company complied with the recommendations made in the preceding Report of Examination. This review determined that the Company had complied, with the exception of the items noted below:

Conflict of Interest

Within the previous examination report, it was recommended that the Company maintain the signed conflict of interest statements for each Board of Director for every year they serve on the Board. It was noted during this examination that the Company's Board members did not complete conflict of interest statements until after the 1999 examination was completed in July 2001. The current audit includes 2000 through 2004. The Company began completing conflict of interest statements in 2001. The Company was unable

to provide a conflict of interest statement for one of the Board members for the year 2001.

Management and Service Agreements

The Management Service Agreement states that the Plan agreed to pay the Authority 12.5% of total premiums collected from enrollees in the prior month. However, the Plan was paying the Authority based on actual expenses incurred. This issue was also noted in the previous examination report.

During 2004, the Company revised its Management Service Agreement to state that the Plan will reimburse the Authority for actual expenses incurred and submitted it for approval to the Alabama Department of Insurance. As of the completion of the examination, the Agreement had not been approved by the Alabama Department of Insurance.

CONTINGENT LIABILITIES AND PENDING LITIGATION

Examination of these items included: a review of the Company's Annual Statement disclosures; a general review of the Company's records and files for unrecorded items; obtaining letters of representation from management; and obtaining letters of inquiry from outside attorneys representing the Company.

As of December 31, 2003, there was no pending litigation against the Company. No material unreported contingencies were identified.

SUBSEQUENT EVENTS

The examiners reviewed general ledger and cash transactions occurring subsequent to the balance sheet date. In addition, examiners inquired of management regarding any significant subsequent events.

The Company entered into a lease agreement with their parent, Huntsville Hospital, on January 1, 2004. The Company agreed to lease office space at their current location for a term of five years.

James Keith Moran, CPA resigned from his position as Director of Financial Services on August 20, 2004. Amanda Evans Parker, CPA is currently the acting Director of Financial Services until the position is permanently filled.

The Company filed for a rate increase of 10% with the Alabama Department of Insurance on September 9, 2004. This application was approved on September 15, 2004, effective January 1, 2005.

At December 31, 2003, the Company was not in compliance with its Bylaws which require a minimum of fifteen board members at all times. Jesse Johnson, Jr. was appointed on February 9, 2004 to fill the vacant position on the Board of Directors making the Company compliant with its Bylaws.

CONCLUSION

Acknowledgement is hereby made of the courteous cooperation extended by all persons representing FirstCommunity Health Plan, Inc. during the course of the examination.

The customary insurance examination procedures, as recommended by the National Association of Insurance Commissioners, have been followed in connection with the verification and valuation of assets and the determination of liabilities set forth in this report.

In addition to the undersigned, Harland Dyer, MAAA, Consulting Actuary; and Lori Wright, Examiner; both representing the Alabama Department of Insurance, participated in this examination of FirstCommunity Health Plan, Inc.

Respectfully submitted,

Tisha R. Freeman
Examiner-in-charge
Alabama Department of Insurance